Provider Communication

Subject:	Changes to Member Co-payments	**Priority:**	**High**
Date:	July 8, 2005	**Message ID:**	ACSBNR07082005_3

Dear Provider,

Changes to Member Co-payments

Effective with dates of service on or after July 1, 2005, the Division is implementing a tiered member co-payment scale on all evaluation and management codes (99201-99499), including Opthometric visits--as described in 42CFR447.54. See co-payment scale below:

Payment for the service chargeable	Maximum co-payment to member
$10 or less	$.50
$10.01 to $25	$1.00
$25.01 to $50	$2.00
$50.01 or more	$3.00

The member co-payment will be deducted from each evaluation and management procedure code billed unless the member is included in one of the exempted, which include: 1) Pregnant women; 2) all members under 21 years of age; 3) Nursing Home Facility residents; and 3) Hospice Care members.

The co-payments does not apply to emergency or family planning services.

The provider may not deny services to any eligible Medicaid member because of the member's inability to pay the co-payment.